

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## **Step 1**

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: \_\_\_\_\_ fax: \_\_\_\_\_

## **Step 2**

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

## **Step 3**

**SEND THE COMPLETED APPLICATION TO:**

**Please make your check payable to: Anthem Blue Cross**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

Thank you for choosing...





Attach Check Here

**Anthem Blue Cross Life and Health Insurance Company  
Individual Dental Blue PPO Plan Enrollment Application**

If you are an Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company subscriber, please enter your current group number and certificate number.

|           |                 |
|-----------|-----------------|
| GROUP NO. | CERTIFICATE NO. |
|-----------|-----------------|

**Check Billing Type Selected**

- Monthly (by checking account deduction only)  
 Bimonthly  Quarterly

Select One

Dental Blue 100 Basic  Dental Blue 200 Essential  Dental Blue 100 Plus  Dental Blue 200 Plus

**Application Information: Applicant must complete this section.**

**PLEASE PRINT**

|  |            |          |  |                         |   |                        |
|--|------------|----------|--|-------------------------|---|------------------------|
| LAST NAME  | FIRST NAME | MI       | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) | MARITAL STATUS<br><input type="checkbox"/> S <input type="checkbox"/> M | SOCIAL SECURITY NUMBER |
| HOME ADDRESS (Must be complete, P.O. Box not acceptable) |            |          | BILLING ADDRESS IF DIFFERENT (or P.O. Box)                   |                         |   |                        |
| CITY   | STATE      | ZIP CODE | CITY   | STATE                   | ZIP CODE  |                        |
| HOME PHONE NO.<br>( )                                    |            |          | BUSINESS PHONE NO.<br>( )                                    |                         |   |                        |

**Spouse To Be Insured (Sign Below)**

|                |  |                         |                        |
|----------------|--|-------------------------|------------------------|
| NAME OF SPOUSE | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) | SOCIAL SECURITY NUMBER |
|----------------|--|-------------------------|------------------------|

**Children To Be Insured**

|                             |     |                         |                             |  |                         |
|-----------------------------|-----|-------------------------|-----------------------------|--|-------------------------|
| NAME (First and Last)<br>1. | SEX | BIRTHDATE (Mo/Day/Year) | NAME (First and Last)<br>3. | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) |
| NAME (First and Last)<br>2. | SEX | BIRTHDATE (Mo/Day/Year) | NAME (First and Last)<br>4. | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) |

**Signatures (Required)**

**Any dispute between you and Anthem Blue Cross/Anthem Blue Cross Life and Health must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both you and Anthem Blue Cross and its affiliates are giving up the right to have any dispute decided in a court of law before a jury.**

**Statement of Understanding for Areas 2, 3, 10, 11 and 12 (counties with limited availability - see pages 12 and 13.)  
 I understand the difference between a Participating Dentist and a Non-Participating Dentist, and would like to apply.  
 I know that I probably will not be able to use a Participating Dentist and that I will probably pay more for dental care. When I use Non-Participating Dentists, I will pay the difference between the limited benefit that the plan pays and the actual charge by the Non-Participating Dentist. This means that I may be responsible for a larger portion of my dental bills.**

|   |              |   |              |
|---|--------------|---|--------------|
| SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN<br><b>X</b>   | TODAY'S DATE | SIGNATURE OF APPLICANT'S SPOUSE<br><b>X</b>                   | TODAY'S DATE |
| SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER<br><b>X</b> | TODAY'S DATE | SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER<br><b>X</b> | TODAY'S DATE |

**Agent Information**

|                                |                    |              |
|--------------------------------|--------------------|--------------|
| SIGNATURE OF AGENT<br><b>X</b> | AGENT NAME (PRINT) | AGENT NUMBER |
|--------------------------------|--------------------|--------------|

**FOR ANTHEM BLUE CROSS ONLY**

|           |                    |           |                |           |      |    |      |
|-----------|--------------------|-----------|----------------|-----------|------|----|------|
| GROUP NO. | CERTIFICATE NUMBER | AGENT NO. | EFFECTIVE DATE | PRE-EXIST | AREA | BY | DATE |
|-----------|--------------------|-----------|----------------|-----------|------|----|------|

|                                     |  |  |  |  |  |  |  |  |  |
|-------------------------------------|--|--|--|--|--|--|--|--|--|
| Applicant Social Security or ID No. |  |  |  |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |  |  |  |

**I. Payment Method** (Premium payment required. Please choose from A or B below.)

**A. Please choose from the following options for initial payment and future payments. If you choose one of these options, you are not required to send in a paper check for initial payment:**

Monthly Checking Account Automatic Premium Payment (complete Section II)                       Monthly Credit/Debit Card (complete Section III)

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**B. Please choose from the options below for your initial premium payment:**

Paper Check\*                       Electronic Check (complete Section IV)

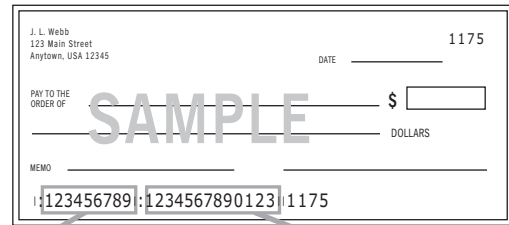
If you chose one of these two options, you will receive a bill every two or three months thereafter, depending on the billing frequency you have selected.

Select Frequency:  Bimonthly     Quarterly

**II. Monthly Checking Account Automatic Premium Payment**

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not sent in an initial premium payment from choice above), your bank account will be debited one month's premium the day after approval. Subsequent premium amounts will be debited on the day you request below.

Requested Debit Day:   (1st to 28th of each month)  
 If no date is requested, your premiums will be debited on the first of each month.



Provide your Routing and Account numbers here.

|                  |                  |
|------------------|------------------|
| Bank Routing No. | Bank Account No. |
|------------------|------------------|

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. **You will incur a \$25 service charge for any withdrawal not honored.**

| Authorized Signature (As it appears in the financial institution's records) | Account Holder Name PRINT | Date |
|---|---------------------------|------|
| X   |                           |      |

**III. Monthly Credit/Debit Card**

As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

We accept Visa, MasterCard, Discover and Star\*.  
 \*For Star, we accept 16 digit card numbers only.

Card No.:  (16 digits only)                      Exp. :  /  Cardholder ZIP Code:

| Authorized Signature (As it appears on the credit card) | Cardholder Name (As it appears on the credit card) PRINT | Date |
|---|--|------|
| X   |  |      |

**IV. Electronic Check**

In lieu of sending a Paper Check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

| Account Holder Name PRINT | Bank Routing No. | Account No. | Amount | Check No. |
|---------------------------|------------------|-------------|--------|-----------|
|                           |                  |             | \$     |           |

\* Enclose check for first month's payment. By sending your paper check, you authorize us to convert your check to an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.  
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